The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

ATTACHMENT 4.19-A

INPATIENT HOSPITAL
Section 100 Payment Methodology

110 Introduction -- Under a Diagnostic Related Group (DRG) system, hospitals are paid a prospectively determined amount for each qualifying patient discharge. DRG weights are established to recognize the relative amount of resources consumed to treat a particular type of patient. The DRG classification scheme assigns each hospital patient to one of over 500 categories or DRGs based on the patient's diagnosis, age and sex, any surgical procedures performed, complicating conditions, and discharge status. Each DRG is assigned a weighting factor which reflects the quantity and type of hospital services generally needed to treat a patient with that condition. Preset prices are assigned to each DRG. In some instances, hospital specific adjustments are made to recognize adverse and favorable selection within a DRG. While it is understood that there will be variations within each DRG, the operational use of the classification system in the determination of relative weights and price levels requires that an adjustment be considered for these cases with unusually low or high use of hospital services. These cases are referred to as outliers. Outlier days are paid when a patient's length of stay exceeds a predetermined limit commonly referred to as "trim point" or "threshold." A per diem payment is allowed for days beyond the threshold. The DRG method of payment is used for inpatient services for Utah hospitals located in urban communities defined by the Standard Metropolitan Statistical Area (SMSA) and for out-of-state hospitals. To assure an equitable payment for Primary Children's Medical Center (PCMC), the normal DRG calculation for 27 DRGs listed in Section 195 is multiplied by 1.40 to cover the necessary cost of highly intense and specialized care. PCMC patients in these DRGs tend to need a very high acuity of care. In many cases PCMC is the only hospital in the State and surrounding areas that can provide the needed care. Exceptions to the DRG payment system include (1) the State Psychiatric Hospital, (2) rural hospitals and (3) specialty hospitals, defined in Section 194. Rural hospitals are defined as Utah hospitals located outside of the SMSA. Rural hospitals are paid a negotiated percentage of allowable usual and customary charges. The base DRG payment covers the services up to the outlier threshold. Therefore, when the inpatient admission is appropriate, there are no partial adjustments for unauthorized or inappropriate days of care until the hospital stay exceeds the outlier threshold.

120 DRGs General -- Except as otherwise provided, the federal DRG methodology definitions are adopted. The Utah Medicaid DRG system does have several unique features. The DRG Utah weights, arithmetic mean average length of stay (ALOS), and outlier threshold days are extracted from Medicaid paid claims history files. The DRG weights are up-dated every eight years or at an earlier date if requested by either the hospitals or the State.

The methods for determining Utah Medicaid weights are explained in Section 121. Where insufficient Utah Medicaid history was available, the weights, arithmetic mean ALOS and threshold days were obtained from the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA). The HCFA data are published in the Federal Register.

HCFA data are adjusted to be compatible with the weights and trim points established with Utah Medicaid paid claims history. In the event HCFA adds new DRG categories, the state will also add those DRGs to be consistent with the certified HCFA DRG grouper tape. The methods used to establish the payment rates and outliers for non-psychiatric DRGs are discussed in Section 121. Payment for psychiatric service provided by acute hospitals is treated separately in Section 300.

The Medicaid dollar conversion factor is based on the FY 1988 expenditure history. The dollar conversion factor is adjusted each year based on the negotiation of a factor for anticipated economic trends and conditions. By signing a provider contract, the hospital agrees to the established payment rate. Furthermore, when economic conditions change during the year, the state may negotiate to change the terms of the contract including the payment rate with each hospital. Each hospital agrees to the DRG payment under a contractual agreement.

Medicaid does not use the Medicare phase in methodology of the blended rate. Rather, the State Medicaid program splits the DRGs into two groups. One group is based on hospital specific dollar conversion factor. The second group is based on a statewide uniform dollar conversion factor. The description of these DRG groups is described in Section 122.

121 DRG Weights and Outliers (Non-psychiatric) -- The DRG weights are intended to reflect relative resource consumption. To establish DRG weights, data used were extracted from the Utah paid claims history files for a two-year period. Where the history did not contain a sufficient number of claims to adequately address the variance in charges and patient lengths of stay, HCFA weights, ALOS and outlier days were adjusted and used.

The Utah DRG weights were established when either there were more than 49 cases or when all of the following conditions were present: a) more than 15 cases, b) a 95% confidence interval with a limit of less than $2,500 of the mean charge, and c) a 95% confidence

interval with a limit of less than 40% above the mean charge. The data base includes FY 1986 and FY 1987 paid claims history. Outlier days were excluded in calculating the ALOS. Also excluded were claims from Primary Children's Medical Center and rural hospitals. The arithmetic mean charge is calculated for each DRG. A statewide arithmetic mean charge for all cases is also calculated. The relative weight of each DRG is a function of the relationship between the arithmetic mean charge for each DRG and the arithmetic mean charge for all applicable DRGs. To determine the relative weight, the arithmetic mean charge for each DRG is divided by the statewide arithmetic mean charge per discharge.

Additional payments are made for discharges meeting specified criteria for unusually long lengths of stay. These long lengths of stay are referred to as "outliers." Medicaid uses the general Medicare methodology for day outliers. However, except as provided in Sections 260 and 420 there are no cost or charge outliers. Outlier days are subject to prepayment review. Payment will not be made for outlier days that are not approved by prepayment review. Most of the Utah DRG outlier thresholds are computed using the lesser of two standard deviations from the ALOS or the ALOS plus six days. However, an alternate approach is used for Utah DRGs that have either high variability or high volume. The following criteria are used to define these DRGs: 1) more than 200 cases, 2) a standard deviation of the charges greater than $3,000 and greater than 75% of the mean charge, 3) an outlier threshold greater than 12 days and a standard deviation of the charges greater than $2,000. Outlier thresholds are established for these DRGs by applying judgment to claims arrayed on a histogram at specified intervals. A reasonable cut-off for lengths of stay is identified on the histogram using judgment. Three DRGs with high variability -- 386, 387 and 462 -- have a threshold set at one. This threshold results in the payment of the DRG per diem at the hospital specific rate for the first day of care and the statewide per diem for all subsequent days of appropriate care. The per diem is based on historical charges adjusted to be consistent with the payment calculated for other DRGs. This approach is adopted because of the extremely high variability of the length of stay in the DRG paid claims history files for the three DRGs. There is also a special calculation for DRGs 433 through 437 involving alcohol and drugs. Because the Medicaid scope of service is limited to detoxification, the payment rate for these DRGs is based on an average length of stay of three days.

122 Dollar Multiplier -- There is a different dollar multiplier depending on which two groups a DRG falls into. The first group is

referenced "A" and includes DRGs priced at a hospital specific rate. The hospital specific rate is calculated by determining the average charge per discharge for each hospital. The average charge for each hospital is adjusted to exclude the variance resulting from the Medicaid DRG case mix index. The Medicaid DRG case mix is calculated by summing the product of discharges times the DRG weights divided by the sum of the discharges. The adjusted average charge for each hospital is then divided by the adjusted average charge for all hospitals. The second group of DRGs is referenced "B" and has a uniform statewide factor. These DRGs are selected because of their relatively low variability and/or low average charge per discharge. Group "B" pays all hospitals the same rate for each DRG regardless of the charge history of the individual hospital.

123 Effective Dates for Rates -- Payment rates will be effective based on "date of discharge." When a patient is transferred from another hospital, as opposed to discharged, the payment will be calculated using the rate in effect at the time of discharge.

130 Property and Education -- The Medicaid DRG payment rates are all inclusive. There are no designated pass-through costs or other add-on factors for costs such as capital, education or other expenditures. However, these factors are reflected in the hospital charge structure used to calculate the hospital specific factor and the DRG payment.

140 Transfer Patients -- Except as otherwise specified in the State Plan, the federal Medicare methodology will be followed for transfer patients. The hospital which transfers the patient will be paid the DRG per diem fee for each day of care. The per diem is determined by calculating the DRG payment and dividing by the ALOS. Except as provided in the State Medicaid Plan, payment to the transferring hospital may not exceed the full prospective DRG payment rate. In cases of distinct rehabilitation units and hospitals excluded from the DRG prospective payment system, the transfers will be considered discharges and the full DRG payment, including outliers, will be paid. Specifically, when a DRG hospital transfers a neonate classified under DRG 385 (neonate died or transferred to another acute care facility) the transferring hospital is paid a DRG per diem for each day of care and is not limited by the DRG ceiling that is typically applied when the transfer payment exceeds the basic DRG payment. To be eligible for Medicaid payments, the exempt distinct rehabilitation unit must be part of an acute hospital. When a person is appropriately admitted and cared for in an acute hospital and is appropriately transferred to another hospital for extended

specialized service and later transferred back to the first hospital, the first hospital is paid the full DRG for the combined stays while the other hospital is paid a per diem under the transfer payment policy. Such per diem payments are not restricted by the DRG payment limitation. Transfers involving hospitals excluded from DRGs will also be paid based on their respective payment methodology.

145 Split Eligibility -- When a Medicaid patient is eligible for only part of the hospital stay, the Medicaid payment will be calculated by the following formula:

> Claim Payment = Medicaid Eligible Days divided by Total Hospital Days x Full Medicaid Payment

The split eligible payment constitutes payment in full for all services rendered on those days on which the patient was eligible for Medicaid and must be accepted as such by the provider hospital. The hospital may not bill the patient for any services rendered on those days. In contrast, the hospital can bill the patient full charges for services rendered during those days that the patient is not eligible for Medicaid. When both third-party payments and split eligibility are involved, the third-party payment will first be applied to the period prior to eligibility. Any remaining TPL will be used to reduce the Medicaid payment.

160 Services Covered by DRG Payments -- Medicaid adopts the general provision of the bundling concepts used by Medicare. Physicians, including resident physicians and nurse anesthetists may bill separately under their own provider numbers. Such billings are in addition to the DRG payment. All other inpatient hospital services, as defined by Medicare, are covered by the DRG system. DRGs are paid for inpatient hospital admissions when a baby is delivered even though the mother or baby is discharged in less than 20 hours.

161 Donor Organs -- Medicaid adopts the general Medicare definitions to determine payment for approved donor organs. Medicare regulations and guidelines are used to establish payment amounts for donated organs.

165 DRG Determinations -- The Medicare DRG "grouper" software will be used for Medicaid. When changes are made, Utah Medicaid will adopt the changes within 31 days of the Medicare implementation date.

INPATIENT HOSPITAL
Section 100 Payment Methodology (Continued)

180 Utilization Review and Control of Inpatient Hospital Services -- Payment may be denied or withheld for inpatient hospital services that do not meet Medicaid regulations or criteria for medical necessity and appropriateness. Medicare regulations and guidelines apply when additional clarification or explanation is required. In the event payment is made and the services are subsequently deemed inappropriate or unnecessary, the payment(s) can be recovered through offsets to future payments. Payment may be denied or withheld in the following circumstances:

1. The inpatient care provided in an acute care facility is not medically necessary based on InterQual Criteria for inpatient admission.

2. The claim is based on an incorrect principal diagnosis.

3. The services or procedures requiring prior authorization have been provided without obtaining the appropriate prior authorization.

4. The patient is transferred when there is no medical justification. In the case of inappropriate transfers, the discharging hospital receives the full DRG and the transferring hospital is denied payment.

5 The patient has been readmitted within 30 days of discharge for the same or similar diagnosis. Except for cases related to pregnancy or chemotherapy, all readmissions within 30 days of a previous discharge will be reviewed to ensure that Medicaid criteria have been met for 1) severity of illness, 2) intensity of service, 3) appropriate discharge planning, and 4) financial impact to the State. Outlier days will be paid where appropriate. In addition, all claims are subject to post payment review.

Determinations of medical necessity and appropriateness will be made in accordance with, but not limited to, the following criteria and protocols:

1. The Diagnostic Group (DRG) system that was established to recognize the relative amount of resources consumed to treat a specific type of patient. The Utah DRG weight, average length of stay (ALOS), and outlier threshold days are extracted from Utah Medicaid paid claims history files where available or from the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA).

2. The comprehensive, clinically-based, patient-focused medical review criteria and system developed by InterQual, Inc.

3. The appropriate, Utah-specific Administrative Rules or criteria developed through the Utilization Review Committee for programs and services not otherwise addressed.

4. The determination, where deemed necessary, of the Utilization Review Committee. The Committee must include at least two physicians and two registered nurses. The Committee will review and make recommendations on complicated or questionable individual cases.

INPATIENT HOSPITAL
Section 100 Payment Methodology (Continued)

190 Exempt Hospitals -- Two categories of hospitals are exempt from DRGs:

The State Hospital will continue to be reimbursed per diem cost for each operating unit. The per diem is calculated using Medicare regulations to define allowable costs. In applying cost reimbursement principles, the Utah State Hospitals required to capitalize only those assets costing more than $5,000.00. A separate per diem is calculated for each operating unit. Therapeutic leave days are included in the total count of Medicaid days, unless the patient was discharged. However, if a patient is admitted as an inpatient to a second hospital, the patient is deemed to be discharged from the State Hospital and the days are not counted. The day count used in the Medicaid cost settlement must be consistently applied for all admissions for all classes and/or groups of patients. Because of their unique patient population, the Utah State Hospital is not part of the DRG system. Medicaid does not use the Medicare methodology to pay an average cost per discharge. TEFRA limits do not apply because of long lengths of stay experienced by many of the patients.

Rural hospitals located in rural areas of the state are exempt from DRG. Medicare definition of "rural hospital" is adopted by Medicaid. Rural hospitals are paid 93 percent of charges.

194 Specialty Out-Of-State Hospitals -- These hospitals provide inpatient services that are not available in the State of Utah. To qualify for this special payment provision, prior authorization must be obtained from the Utah State Department of Health, Division of Health Care Financing. The payment amount will be established by direct negotiations for each approved patient. The DRG method may or may not be used depending on the negotiated payment. Typically, the Medicaid rate in the state where the hospital is located is paid.

195 Specialty Utah Hospital -- Primary Children's Medical Center (PCMC) is a unique hospital for children. Many patients who are admitted to this hospital cannot receive the needed services from any other hospital in the state. Twenty-seven DRGs have been identified that cover services to children with the most severe medical problems. Only PCMC can meet the needs of many of these children. The twenty-seven DRGs are 26, 55, 58, 81, 103, 110, 124, 125, 137, 139, 156, 184, 214, 215, 234, 385, 386, 387, 389, 390, 396, 397, 417, 422, 451, 475, and 486. The normal DRG payment calculations for these 27 DRGs are multiplied by 1.40 to assure adequate payment for specialty services required by children.

196 Short Stays -- Generally, patients discharged from the hospitals in less than 24 hours are classified and billed as "outpatient". An exception to this policy involves maternity care. DRGs 370-375 and 385-391 cover deliveries and babies. These services are paid as inpatient services under the DRG system.

Section 200 Other Payments

210 Small Volume Utah and Out-of-State Hospitals -- Except as provided in Section 191, payment will be made under the same DRG methodology as in-state urban hospitals. The hospital specific factor will be the lowest factor for an urban hospital in Utah with over $100,000 in Medicaid payments during the prior fiscal year.

240 Sub-acute Care and Swing-beds -- This policy pertains to patients that do not require acute hospital care.

-- When sub-acute care patients receive medically necessary services in an inpatient hospital setting, payment is made at the swing-bed rate. Because sub-acute patients require a lower level of care, the rate is lower than the rate paid for acute hospital services. The sub-acute rate is calculated using the criteria specified in 42 CFR 447.280(a)(1).

-- When nursing home beds are not immediately available in the community, patients may receive skilled or intermediate nursing care in a bed of a qualified hospital. Rural hospitals typically qualify for the swing-bed program. Payment is made at the swing-bed rate using the criteria specified in 42 CFR 447.280(a)(1). Patients are transferred to licensed nursing home beds in certified facilities when such beds are available in the community.

241 Insignificant Billing Variances -- When the Medicaid payment is determined using the billed usual and customary charges (i.e. rural hospitals), insignificant billing errors may be processed. To expedite payment and to reduce administrative effort, Medicaid pays the lesser of the detailed charges or the total charges, if the difference is ten dollars or less.

250 Payment for Emergency Days -- Emergency days for inpatient psychiatric service cover the time between admission and the first service date authorized by the Medicaid prior authorization staff. Emergency days under the DRG system will be paid a per diem for each approved day. As with transfer patients, the DRG per diem will be calculated by dividing the DRG payment by the geometric mean length of stay.

251 Third-party Payment -- When insurance or other third-party payors have responsibility for payment, Medicaid is the payor of last resort. The amount paid by Medicaid is limited to the patient's liability. Further, Medicaid payment for specified Medicare cross-over claims will be the lower of: 1) the allowed Medicaid payment rate less the amounts paid by Medicare and other payors, or 2) the Medicare co-insurance and deductibles.

252 Interim Payments -- There are two types of interim payments for DRG hospitals. First, hospital stays in excess of 90 days may be billed under the DRG system prior to discharge with prior approval. The interim bill is paid at 60% of the allowed charge. Second, an interim payment may be granted when the lag time between the date of service and the date of payment for a specific hospital is above the "mean" processing time for all DRG hospitals. In addition, the hospital requesting the interim payment must be able to document a cash flow problem that could impair patient care. The amount of the interim payment is based on the cash flow needs of the hospital not to exceed the Medicaid interim payment limit. The interim payment limit is calculated by multiplying the number of days above the "mean" processing time by the average daily Medicaid payment.

260 Exceptionally high costs and long lengths of stay -- Medicaid patients under the age of one receive an additional payment for exceptionally high cost and exceptionally long lengths of stay. The payment is termed an "outlier payment". Exceptionally high cost is defined as inpatient hospital charges in excess of $500,000. Exceptionally long lengths of stay are defined as 260 days. The additional payment will be one tenth of one percent of the Medicaid payment calculated without the outlier payment.